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The Problem of Complementary and Alternative Medicine Use Today: Eyes Half Closed?

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Abstract

Commentators like Goldacre, Dawkins, and Singh and Ernst are worried that the rise in complementary and alternative medicine (CAM) represents a flight from science propagated by enemies of reason. We outline what kind of problem CAM use is for these commentators and find that users of CAM are constituted as duped, ignorant, irrational, or immoral to explain CAM use. However, this form of problematization can be described as a flight from social science. We explore CAM use in light of the rigorous and robust social scientific body of knowledge. By pointing to the push and pull factors, CAM user's experiences of their body, and the problem of patient choice in CAM use, we summarize some of the key findings made by social scientists and show how they trouble many of the reasoned assumptions about CAM use.

Keywords

evidence-based practice; health care, alternative and complementary; knowledge utilization; meta-analysis; research, mixed methods; sociology

> People who choose to see alternative therapists make that choice with their eyes open, or at least only half closed. (Goldacre, 2008, p. 318)

In an otherwise contentious field commonly referred to as complementary and alternative medicine (CAM) in Western societies there seems to be some kind of consensus around one thing: The past few decades have been marked by a growing interest in, and a revival of CAM (Cant & Sharma, 1999; World Health Organization, 2002). More recently very public controversies and debates have been concerned with questions about how to respond to such trends. In popular media reporting around CAM, we distinguish between three points of view. First, there are advocates who actively encourage and laud the revival often as an antidote to a toxic biomedicine. Second, there are pragmatists who argue that if use and availability of CAM is increasing, then appropriate regulatory measures must be taken to ensure that its products are safe and its practitioners responsible and ethical. Finally, there are opponents who are deeply concerned, worried that a rise in CAM is putting patient safety at risk as unknowing and ignorant consumers are being duped into buying snake oils and miracle cures by "enemies of reason" (Dawkins, 2007a).

We engage this latter group of vocal commentators in this article. We begin by outlining what kind of problem CAM *use* is today for this group of concerned commentators.[1] We ask, how has growing interest in and use of CAM[2] by the public come to be cast as a problem? In answering this we show how characterizations of CAM users as duped, irrational, ignorant, or immoral are inaccurate and unhelpful if we are to understand CAM use.

We argue that the problematization of CAM by this group of commentators might itself be described as a flight from science; albeit not the science of randomized placebo controlled trials, meta-analyses and preclinical mechanism-of-action studies that are usually advocated. For

it does seem somewhat peculiar to account for the health care practices, choices and preferences of individuals without paying particular empirical attention to the social context in which individuals take care of their health. In the last few decades, a rigorous and robust social scientific body of knowledge around exactly these kinds of questions has emerged around the field of CAM. In the second part of this article we summarize some of the key findings of this work as a way to trouble the above mentioned characterizations of CAM users.

In the conclusion we argue that it would be better for all if the different scientific worlds engaged in more dialogue. If clinical science can answer questions about which specific effects are attributable to a particular therapy, and biological science can answer questions about the cellular and molecular pathways of diseases and treatments, then social science can answer questions about the ways social factors affect how and why certain forms of health care are practiced and used. Addressing questions of CAM use is therefore a useful arena in which to observe each of these forms of science in action, and if we are to account for a rise in CAM use and availability, we will do well to bring all forms of knowledge into the analysis.

CAM subjects – duped, ignorant, irrational, or immoral

> It has become fashionable (and politically correct) to ask patients to present their views. In CAM meetings, this usually entails a patient telling the audience how marvelous her (it usually is a woman) Reiki healer, aromatherapist etc, has been compared to her ghastly experience with mainstream medicine. These lectures are usually loaded with emotion and devoid of anything remotely resembling data, evidence or rational thought. (Ernst, 2011)

In this section we consider some of the arguments and understandings of CAM use by a particular group of critics. Trained in natural or biomedical sciences, they are very vocal commentators, publishing and broadcasting in newspapers and television stations in the United

Kingdom, United States and elsewhere. Focusing on their arguments allowed us to identify the different ways in which CAM use has been characterized in recent years and how it has come to be identified as problematic.[3] Their explorations mostly take their point of departure in discussions about the safety and efficacy of treatments, whether by focusing on one or a small number of popular treatments, such as homeopathy and acupuncture, or through a consideration of CAM in general. Although not necessarily a central question for them, their arguments often included assertions (both explicit and implicit) about the people who use CAM. What emerged from an analysis of their arguments is a characterization of users of CAM as duped, ignorant, irrational or immoral.

Duped

One of the most well-known opponents of CAM is Richard Dawkins (2007a), who has outlined the problem in the starkest of terms: "Today, while we indulge unproven healing magic, tried and tested scientific medicine is under attack. . . . Health has become a battleground between reason and superstition" (*Enemies of Reason: episode one*). Dawkins argued:

> Alternative health remedies are swamping us. Most are not properly tested; they undermine science and delude the public. . . . Resuscitating [ancient forms of medicine] today is rather like bringing back bleeding with leeches. . . . developed before we understood the causes of disease, before germ theory, it was based on ignorance then, and age makes it no truer. We misguidedly look back to a Golden Age that never was. (*Enemies of Reason: episode two*; Dawkins, 2007b)

Dawkins is joined by Michael Baum and Edzard Ernst (2009) in his condemnation: "By opening the door to irrational medicine alongside evidence based medicine, we are poisoning the minds of the public" (p. 973).

The narrative is of the user being deceived by the pseudo knowledge of the CAM advocate. Over the years, analogies have changed from CAM users being duped into its esoteric ways, like the innocent housewife faced with the charming snake oil salesman, to today where customers are duped by multimillion pound industry with its slick advertising (Diamond, 2001; Goldacre, 2008). Nevertheless, this is no one way street. It would seem there is a battle going on for the health of the public, one where the user needs to be educated about the power of scientific knowledge.

Ignorant

One of the key arguments for those defending reason is the Public Understanding of Science (PUS) position, or rather, the notion that it is the public's failure to understand science which leads them to use CAM. The argument goes something like this: If people only understood the power of the scientific method and learnt how to think scientifically, they would come to appreciate all that science has given them and come to view sham or pseudoscience with the disdain it deserves. Consequently, the task of the expert is to educate the public to correct any mistaken beliefs. Two recent books – *Trick or Treatment?* by Singh and Ernst (2009) and *Bad Science* by Goldacre (2008) – reflect this tactic. Singh and Ernst have a whole chapter explaining the scientific method and Goldacre's book is similarly a pedagogic exercise in applying this idea: "by the end of this book you'll have the tools to win – or at least understand – any argument you choose to initiate" (p. xii). However, for those users who fail to accept the truths derived from scientific rationalism there is still a need to articulate why they continue to use CAM.

Irrational

In the opening pages of his book, Goldacre (2008) argued: "You cannot reason people out of positions they did not reason themselves into" (p. xii). This is a sentiment that is shared by Fitzpatrick (2002) who suggested: "Though numerous trials have already revealed that such

treatments do not work, these results are simply denied or ignored: faith in alternatives cannot be challenged by such methods. These researches lead only to the demand for more researches". Similarly Ernst (2006) said:

> Almost everyone seems to be an 'expert' in CAM. . . . A more appropriate name for this phenomenon is probably 'pseudoexperts'. It helps, I think, not to be too intelligent. This makes it easier for the pseudoexpert to fall victim to his or her own powers of persuasion. The result is often an almost religious belief of the pseudoexpert in the correctness of his or her assertions. (p.85)

In yet another vocal critique of CAM, Michael Baum (2009) has lamented that much of the use of CAM can be laid at the door of postmodern relativism – the idea that all opinions and knowledge have equal values. Coupled with this, he stated, is a distrust of authority and scientists, as much as in the science itself. Faith, religion, unreasoned positions and postmodern relativism, each represent a version of irrationality on the part of CAM user.

Immoral

The critiques of CAM use also raise questions about CAM framed as a moral problem. Again, Dawkins summarized this neatly saying, "As a scientist I do not think that our indulgence of irrational superstition is harmless, I believe that it profoundly undermines our civilization" (Dawkins, 2007b). Although Goldacre (2008) largely aimed his moralizing at CAM practitioners, as we can see in this article's epigraph, he also asserted the culpability of the user in these unscientific ways of life. Goldacre's criticism of CAM was not just that it provided placebo treatments, but that it provided placebo explanations or placebo diagnosis. He questioned the benefits of this combination, even allowing for the physical benefits that it provided the patient, "assertively and authoritatively giving someone access to the sick role can also reinforce

destructive illness beliefs and behaviors, unnecessarily medicalize symptoms. . . . and militate against people getting on with life and getting better" (p.75).

Summing up

We have outlined how a vocal group of commentators on CAM efficacy have included in their critiques a problematization of CAM users. They start by asserting the unproblematic nature of the evidence against (most) CAMs. The user is then depicted as someone who once was (half) blind but now because of the revelation of scientific method and knowledge, can see. However the problem of CAM use somehow persists, and has led to ever more determined attempts to implore the user to come to her senses, while blaming her for the continued resilience of CAM.

In concluding this section we would like to make it clear that although we have briefly summarized characterizations of CAM users under four simplistic headings, we do not wish to create a straw argument here. The above analysis is not a rejection of discussions concerning the efficacy of CAM. Although there are limitations to such efficacy discussions (e.g. Barry, 2006; Broom & Tovey, 2007), we do not wish to distract from some of the important findings the above authors have highlighted, such as pointing to the dangers of using CAM in preference to established biomedical treatments.

We also acknowledge that these commentators have recognized and attempted to engage the psychological, social, cultural, political, economic and even spiritual components of health care and CAM use. For example, Singh and Ernst (2009) concluded, "Alternative medicine is not so much about the treatments we discuss in this book, but about the therapeutic relationship" (p.326). Baum (2009) suggested, "Before health service providers even think about the role of medicine, they must consider patients' requirement for moral and spiritual support" (p.409). Goldacre (2008) underlined the importance of culture in discussions of health care suggesting that many CAM practices are "better understood as a cultural product" (p.10).

Given the background and central aims of these commentators it is no surprise that their analytical focus is on the evidence from randomized controlled trials (RCTs). However, as they acknowledge, "it is a little more complicated than that" (with thanks to Goldacre). The conclusion that seems so obvious (to us as social scientists, at least) from analyzing their books and articles is that the problem of CAM use is not a problem of scientific evidence and clinical efficacy (unlike the problem of does CAM work? (Wahlberg, 2008)). It is a social and cultural problem; a problem that has more to do with how we know ourselves as bodies, citizens, and consumers in the world. The authors above have led many public debates on CAM, but appear not to be equipped conceptually, as much as empirically, to handle the conclusions they come to. If CAM use is a social and cultural problem, it seems remarkable that significant social science research into such problems are systematically overlooked if not explicitly shunned. As Ernst and Chatwin (2005) noted in their debate, the value of social science is easily downplayed:

> Focus groups, interviews, text analysis and similar techniques are almost a caricature of sociology. Usually such qualitative methods are helpful for formulating but useless for testing hypotheses. . . . the results of such research can rarely be generalised. If results cannot be generalised, what exactly are their value? (p.16)

How then might we address this apparent flight from social science in mainstream debates concerning CAM use? To begin with, it is one of our tasks as qualitative health researchers to explain and stand by the value of our research findings. With this in mind, we now turn our attention to the social science of CAM use.

What social scientists have found out about CAM use

We consider here some of the evidence that can help explain how CAM has become culturally, if not medically, successful. However, in the space we have available we will not be able to do

justice to the large, detailed, and growing amount of evidence that is available on CAM use. Nor can we introduce the field of social studies of CAM use, which has been well summarized elsewhere (e.g. Kelner et al., 2000).[4] Instead we seek to outline a series of the more established arguments using the relevant evidence from our meta-study of social science and CAM literature, to help focus on reconceptualizing the problems that the above commentators have posed. As Paterson et al. (2001) have argued it is possible to carry out a "meta-study" of qualitative health research as a "means of building generalizable knowledge from bodies of individual qualitative research reports on particular phenomena" (p.2). In contrast to meta-analyses of clinical trials, we have not developed systematized inclusion criteria for our reading. Rather we have pooled our respective knowledge of the social science and CAM field to synthesize the findings of those studies that have specifically included engagement with the users of CAM through interviews, ethnographic participation or focus groups.

Any attempt to understand CAM on a general level is fraught with difficulties, caveats and exceptions. As O'Connor (2000) described, many CAMs draw on a specific philosophy and understanding – meaning that many similar sounding concepts are not comparable across their contextualized states. Similarly, she found that the intra-related and mutually generative nature of some concepts within a particular CAM made them extremely difficult to separate out and define singularly. When possible, we argue, these problems should be highlighted not as negative attributes, but as part of the empirical reality that is central to any developed understanding of CAM use. Likewise, Broom and Tovey (2008) highlighted how unquestioned categorizations of Western, orthodox or modern medicine is also problematic because of the a priori geopolitical and ideological distinctions inherent in such terms. Although in this article we prefer the term biomedicine, because it better situates the ideas and practices under consideration (Broom &

Tovey, 2008), the complex problems in understanding biomedicine are again issues that need to be in the foreground in any analysis.

Push and Pull

When exploring the evidence for why people use CAM we argue that it is unhelpful to polarize the debate so that use of CAM automatically generates a negative (or positive) response. Rather, it is more helpful to understand when, why and how CAM is used. In doing so we can come to understand the user of CAM as situated within a multitude of push and pull forces, none of which can be said to be explanatory in general, although they might be causally significant for specific instances.

CAM use has been related to negative experiences or iatrogenic effects of biomedicine. Patients often report that their experiences of illness are secondary to the clinician's measurements and models of disease and the body (McClean, 2005). The origins of dissatisfaction with biomedical treatments can range from poor doctor-patient relationships, perceived or actual ineffectiveness of treatments (particularly in many chronic illnesses), through to negative or harmful reactions to treatment (Corner et al., 2009).

There is also evidence to suggest that the effect of the rise of CAM is not necessarily a direct challenge to the biomedical establishment. Different CAM models and their rationales provide varying degrees of contrast to that of biomedicine, whereas the biomedical establishment has shown some capacity to incorporate a number of complementary practices, particularly when a CAM regulatory body has shown willingness to utilize RCTs to test their claims (Saks, 2000).

This hybridization is reflected in patient's attitudes toward, and use of, CAM. For example, Thomas et al. (1991) found that the majority of patients (64%) had received biomedical care for the illness they took to the CAM practitioner. Just under a quarter of those continued to do so at the same time as seeing the CAM practitioner, with the other 36% not receiving any

treatment from their biomedical practitioner (usually their GP). Therefore, more than twenty years ago, Thomas et al. rejected the view that patients attending CAM therapists did not appreciate or understand the benefit of biomedicine or that the popularity of CAM represents a flight from science. In summary, they found that CAM was used as a supplement rather than a substitute for biomedical care – a finding that Furnham and Vincent (2000) found replicated in many studies since.

In this personalizing hybridization of treatments Lewith and Chan (2002) found that people used very similar criteria to evaluate CAM and biomedicines, which contextualize efficacy within other concerns such as time, side effects and cost. They also noted that the user's choice of treatment was based largely on the type of illness they were suffering from, with those suffering from chronic illness more likely to engage CAM. In summary, the evidence showed patients were not wholly skeptical of biomedicine and blindly accepting of CAM (Britten, 2008; Broom & Tovey, 2008).

Another push or pull factor is that patients look to distinguish between treatments and practitioners who empower or disempower (Sharma, 1994). Empowering strategies of control have been identified as part of ways of coping with illness (Honda & Jacobson, 2005). Furthermore, user's talk of control and empowerment were seen to easily tap into wider policy narratives of patient choice. For example, Leiser (2003), in his study of patterns of belief among users of CAM, concluded that support for CAM was "characteristic of patients with a self-aware lifestyle and a more active approach to managing their problems" (p.461). Foote-Ardah (2003) also suggested that using CAM was "a matter of self-regulation of treatment regimens aimed to manage everyday life by increasing personal control" (p.482).

Many clinicians have therefore considered user's engagement with CAM as part of the patient's desire to establish control over their illness and body and as part of managing the

uncertainty that many diagnoses bring (Broom & Adams, 2009). To this extent biomedical practitioners, like Baum (discussed above), have incorporated some CAM as part of a psychological support repertoire for patients, a role for CAM that is found to have some basis in evidence. However, as Broom and Adams (2009) described, there remains a divergence between the biomedical practitioner's and user's perspective concerning CAM use.

The evidence suggests that it is not as simple as biomedicine just making space for CAM practices. O'Connor (2000) argued that the attempts by biomedicine to welcome CAM via RCTs and the evidence based medicine agenda fail to understand that the integrative approach is based on a flawed assumption: That as the project progresses, those CAMs that work will be incorporated and those that do not will be shown to be ineffectual and therefore lose favor and popularity. O'Connor reasoned that the ongoing use of CAM treatments, in the face of the great advances of biomedicine, strongly suggested that this assumption is false. She went on to argue that this is not because it is the material (biological) efficacy of CAM that is so attractive, but the robustness of their,

> popular epistemologies and ontologies that diverge from the scientific worldview; their profound connections to personally and collectively convincing and meaningful experiences of the body, of health, of illness, and of healing; and the extent to which complementary medical systems incorporate and address these issues. (p.57).

That is to say, its symbolic rather than material efficacy (see Wahlberg, 2008). O'Connor concluded that it was of uppermost importance to remember that understanding CAM use has therefore to take into account the issues and experiences of those using CAM "*as they themselves define them*" (p.57, emphasis in the original). In summary, the social scientific literature shows that people want to understand the meaning of illness, as much as they want to be cured (Britten,

2008), and when biomedicine cannot or fails to assist them in this endeavor, they will look elsewhere using their body as a testing ground for meaning.

Embodied users

A common emphasis in CAM use is its holistic approach to the person; but what does this mean and what does it tell us about CAM use? Given what we have already discussed, understanding the contemporary patient necessitates a different framework of consideration than just what is available in the biomedical understanding of the body. As Fraser and Greco (2005) summarized, there has been a considerable shift in the postwar years in how the body is understood, and not just by biomedicine. It is impossible to do justice in a few lines to the shifts that have taken place, but they described the move to postindustrial society and the (perceived) concomitant increases in both wealth and leisure time for large portions of society. Fraser and Greco also highlighted how the body came to the foreground in political liberation movements, such as feminism, antiracism and ableism movements, many of which contain an anti-positivist element. The result of these cultural shifts is that the body is no longer – if it ever was – a single domain of science and medicine. The evidence and rhetoric from many CAM users and providers is that CAM is better able and better predisposed to serve these new needs of the body (e.g. Broom & Tovey, 2008).

As the quote from Ernst (above) shows, perceptions of CAM use can be highly gendered. This could be seen simply as an acknowledgment of the main demographic characteristic of CAM users (Bishop & Lewith, 2010). However, many social scientists have pointed to the dualism that exists in biomedicine, extending de Beauvoir's (1949/2009) observation that women are the Other to the male normal to show how women's experiences and knowledge of their bodies are excluded from biomedical discourses. In response, some have argued that use of CAM allows women to address this deficit by empowering a subjective experience that includes wider social and environmental issues related to health care (Scott, 1998). CAM has also been found to

relate embodied experiences of healing and wellbeing that go beyond physiological concerns to connect to wider social and cultural perceptions of body images (Sointu, 2006a). Of course, CAM is not without its own problems in identity and cultural formation (Stacey, 1997; Sointu, 2006b, 2011; Nissen, 2012); but the point we wish to make here is that reasons for CAM use are embodied within a sociocultural milieu that, in turn, affects how we perceive users of CAM.

The user of CAM is better understood as seeking to go beyond (rather than reject) the materiality of the biomedical body, which is seen as too limited to encapsulate the many aspects of human existence and experiences (Sointu, 2006b). These immaterial considerations can include intelligence, the mind, the soul or spirit, a person's psyche (metaphysical as well as neurological), a vital force and/or energy (O'Connor, 2000). Biomedicine's authoritative claims about the nature of illness and disease are therefore challenged (McClean, 2005). As O'Connor, (2000) argued this was because, first, it restricted what was valid knowledge to that which had been generated via certain controlled methods, by certain professional people. Second, she observed that biomedical system's validity does not always resonate with laypeople's own experiences and observations, which are increasingly felt to be the best sources for authoritative knowledge in contexts where professional knowledge is neither available nor wanted.

Although biomedicine resists or rejects such idiosyncratic claims, CAM is more open to such lay empirical based knowledge. O'Connor (2000) found that when CAM users brought personal experience together with knowledge of one's body it generated a "practical epistemology" (p.54), whereby one's own judgments were the basis of efficacy of a treatment or experience. However this is not a move to solipsistic irrationality, because even when other (biomedical) treatments have failed, users of CAM will still use scientific logic and reasoning as

part of their empirical self-testing of CAM on oneself (Hök et al., 2007). Again, the importance of how CAM is actually used finds us located in a multidisciplinary middle ground.

It is this complex picture to which social science has attended. It is not possible, as Broom and Tovey (2007) have argued, to reduce the complexity of what is happening down to some simple argument or perceived social trend, such as postmodernism, which has been found to hold little explanatory power in practice. As a conceptual minimum Broom and Tovey argued that CAM use can be understood within the "depersonalization" that comes with advances in bioscience and medicine and the wider social process of "individualization" that locates the individual as the moral site of autonomy. However both of these terms contain a complexity that needs to be understood within the site of CAM itself. They are not a priori explanations, but indicators of what to look for when one attends to the field of CAM use. They also need to be located, Broom and Tovey (2007) argued, within the demographic and physiological confines of each person's illness.

For this reason a lot of CAM research attends to users' stories and narratives within them. This is because, Frank (1995) reasoned, people's stories of their lives figure prominently in the ways we seek to understand experiences of illness. Frank found that those who were previously the subject of stories, such as those from biomedicine, now fashioned their own accounts to "speak her own truth, in her own words" (p. xiii). Listening to these voices demands a different set of analytical tools and a respect for what those tools can show us.

For an example of the important difference recognizing stories and the narratives within them makes, let us address the problem of the reformulation of medical and scientific categories and consider the consequent implications on the individual's identity. As Mathieson and Stam (1995) stated "medical talk becomes part of an illness narrative to the extent that it fits the renegotiation of identity. Words such as 'cancer,' 'tumor,' 'chemotherapy' and the like have

meaning only to the extent that they form part of the patient's ongoing identity work" (p.302). A patient will first learn about their disease and the nature of medical discourse around it and then decide how they fit into that discourse. "It is at once a participation in the global cancer narrative and idiosyncratic because patients must learn a cancer vocabulary in order to articulate *their* concerns" (p.298, emphasis in the original). In working on their own accounts of their bodies people will draw on the cultural reference points available to them. One source of these is CAM.

Critiques of CAM use would point out that CAM only serves to complicate matters, in particular around biomedicine's precise scientific terminology, much to the detriment of the patient (Baum, 2009; Dawkins, 2007a; Goldacre, 2008). Putting to one side the philosophical linguistic problems of this position, it is an argument that returns medicine to the position of paternalistic authority figure. As Charles et al. (1998) found, the model used is one where the patient is someone to whom the doctor can impart the necessary knowledge and who will absorb and utilize the information as a rational actor. In this way the evidence based model for doctors is equated with a rational decision making patient. Hence, if the patient deviates from the scientific evidence they are labeled as irrational and it is the duty of the physician to protect them. However, as Charles et al. argued, in this model "[p]aternalism comes a full circle. This model leaves no active role for the patient in interpreting the scientific information or in trying to make it personally meaningful" (p.88).

Alternatively, narrative based research has found that CAM does allow users to increase control of their illness and attempt to normalize their health status. CAM was found to do this by providing individualized ways of managing symptoms, medications and emotions, through self-exploration and providing complementary and alternative frameworks of understanding and meaning (O'Connor, 2002). Indeed, Sharma (1992) has argued that CAM provided individuals with,

> a new way of looking at their illnesses, that sense of a more relevant order being imposed on problematic experiences [and]. . . . insofar as this new interpretation is found acceptable and creates positive feelings of comfort and confidence on the part of the patient, then there is a sense in which it has "worked". (p. 72)

Central to much of this is the reevaluation of the relationship between the mind and the body. The idea, or caricature, of the Cartesian-self posits that in the seventeenth century René Descartes separated the mind, which became the preserve of religion and moral philosophy, from the body, which was handed to the scientists and doctors (Harrington, 2008). Regardless of the factual accuracy of this depiction, it is a narrative that now permeates both CAM (e.g. McClean, 2006) and biomedical understandings of the person (e.g. Greco, 1998). For CAM users the mind body problem is often referred to as part of the psychosomatic component to illness or, borrowing from a burgeoning bioscience, as the psychoneuroimmunological aspect of illness (Harrington, 2008). CAM use therefore allows the user to relate their physical experience of illness to the many intangible aspects of their life. At the same time, it brings hope that working on the bio-neuro-chemical pathways might alleviate the physical presence of many (iatrogenic) symptoms, if not the illness itself.

What we have begun to outline here is the importance of subjective understandings of the body and mind in formations of the self for people who use CAM. We find that people bring together multiple ways of knowing and experiencing to contemplate their situation and to make sense of what is happening. In particular in illness, perhaps more than any other time in life, people become acutely aware of their embodied constraints. However, through the stories they tell to themselves and others they are able to emplot new pasts, presents and futures. People also become more aware of their relations to others, drawing on their affective responses as a measure

and predictor of their circumstances. Within this, the categories and discourses of biomedicine and CAM (among others) become resources on which to draw to form and reform oneself, health and life.

The problem of patient choice

Social science research on CAM use has repeatedly shown that insisting on a clear separation of CAM from biomedicine simply does not bear up to empirical scrutiny, whether on the part of patients or practitioners (McClean, 2006; Johannessen & Lazar, 2005). Individuals are notoriously unfaithful to any one particular form of therapy, electing instead to try different options or combinations until they find something that works for them (Britten, 2008; O'Connor, 1995).

This brings us to the problem of patient choice, i.e. the notion that patients are the experts (of their lives) and thereby in the best position to know which therapy or treatment approach is best for them. There is an important social scientific literature on patient choice in the context of biomedical practice, which we cannot cover within the scope of this article. What we will discuss instead is how social scientific research on CAM use weighs in on the problem of patient choice.

Patient choice can be understood in the context of what Janzen (1978) has called a "quest for therapy" (p.37) and Augé (1985) "therapeutic itineraries", namely "the routes taken by people who wish to be cured of an illness or malaise" (p.12). Although the figure of the CAM consumer who "shops around" has also been invoked (Cant & Sharma, 1999, p.37), it is more helpful to think in terms of routes and itineraries, because these encompass more than commercial transactions and can include such things as lay referral networks, information gathering activities and processes of socialization. Peglidou (2010) has shown how "in the open-ended process of therapeutic trajectories . . . different and heterogeneous healing practices often alternate, each employing a variety of concepts of the body, soul, sickness and healing" (p.51).

What the notion of routes therefore helps to contextualize is the point that choices are rarely made in isolation but rather in the context of what Sleeboom-Faulkner (2010) has called "frameworks of choice" – "choices are a product of circumstances and structural factors, which delimit and condition the choices individuals, families and communities make" (p.13). In the context of healing, choice relates to opting for, pursuing and tacking between certain courses of action. What the qualitative studies considered here have shown is that such decisions are reasoned through, discussed and lay researched by individuals along the way, at the same time as being subject to the normalizing discourses of rational or appropriate use of various forms of medicines (Johannessen & Lazar, 2005). The point being that, in matters of choice, it is a "patient's authoritative agency" (O'Connor, 1995, p.162) – however socially conditioned, structurated or habitus infused – which is in focus. It is also this active patient that somehow contrasts to the passive recipient of evidence based medicine.

Conclusion

Having reviewed social science findings regarding the use of CAM, the figure of the duped, ignorant, irrational or immoral CAM user seems somehow distant and faded. Instead we have met individuals following socially mediated therapeutic itineraries, actively reflecting on and reasoning about their actions, embracing certain narrative accounts, and rejecting others. These are the kinds of findings that emerge when CAM users are consulted – in a systematized, rigorous and reflective manner – as a way to account for their CAM use.

One can already imagine a likely response from those vocal commentators with whom we began this article: What you have summarized here only confirms what we suggest, CAM users are ignorant at best and deluded at worst regardless of how they ended up as CAM users. Perhaps even worse than that, by making sense of their actions social scientists are in fact legitimizing

dangerous therapeutic practices. Again, Ernst and Chatwin's (2005) debate posed important questions:

> Could sociological CAM research do any harm? I fear the answer might be yes. It tends to describe phenomena such as CAM's growing popularity and acceptance, patients' reasons for using CAM, patients' satisfaction, etc. The interpretations that are then put on the findings (by sociologists and others) lend themselves to some type of legitimisation or justification, often even promotion, of CAM . . . the research agenda of sociologists often tacitly assumes the efficacy and safety of CAM. Since these assumptions are often not met, the results of such investigations are prone to mislead. (p.17)

However, accounting for CAM use, of course, tells us nothing about whether or not CAM should or should not be used in a particular context. Although one might be tempted to read this article as a dismissal of evidence based medicine, this is far from being the case. To put it simply, if one is interested in accounting for CAM use then clinical trials, assays, toxicology tests are not your best bet. Likewise, if you are interested in the (lacking) biological mechanisms-of-action of a given therapy, semi-structured interviews, fieldwork and participant observation are not suitable.

What we have suggested in this article is those analyses that look on the user of CAM as duped, ignorant, deluded or immoral are simply not helpful – from an analytical, pragmatic, public health, or other perspective. This does not mean that important questions around the safety of CAM (or any other kind of therapy for that matter) should not be addressed. Indeed, the group of commentators we have engaged with in this article have been at the forefront of calling for robust attention to patient safety. However, as we have shown, the problem of CAM use cannot be resolved through generalized assumptions about the user based on laboratory or clinical practices alone.

Notes

1. See Wahlberg (2007) for an analysis of how the problem of 'CAM practice' has come to be cast in the United Kingdom in recent years.

2. There is a large debate concerning whether or not there has in fact been growing interest or rising use of CAM in the last decades in the United Kingdom (see McClean, 2006; Moore & McClean, 2010). In this article, we are not so much interested in whether or not CAM use is on the rise, but rather about how a rising use of CAM is considered a problem.

3. One could also focus on reports and guidelines from the National Health Service and Department of Health, or on advice from CAM practitioners about the appropriate/inappropriate use of various forms of CAM therapy.

4. We have not always cited the most recent evidence to substantiate our arguments because we wished to avoid, where possible, using evidence that was not available to those who have critiqued users of CAM at the time they published their analyses.

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